



Surgical Care Affiliates

## **Alaska Surgery Center**

*an affiliate of* **SCA**

### **Conditions for Coverage**

### **Information Packet**

- **Advance Directive**
- **Notice of Patients Rights and Responsibilities**
- **Physician Ownership Disclosure Statement**



**Surgical Care Affiliates**  
**AK Surgery Center**

*an affiliate of* **SCA**

Dear Patient:

We look forward to your upcoming visit at the Surgical Care Affiliates center. It is the policy of Surgical Care Affiliates to notify you of the following information prior to your arrival at the center on your day of service:

1. Notice of Patient Rights and Responsibilities:  
(Please see attached)
2. Physician Ownership Disclosure:  
(Please see attached)
3. Center policy regarding Advance Directives including a description of applicable State health and safety laws: (Please see attached)
  - A. You have the right to make choices regarding life-sustaining treatment, including resuscitative measures.
  - B. The Surgical Care Affiliates facility where you are scheduled to have your procedure wishes to notify you that if there is a need to transfer you to a hospital for additional care measures beyond what the ambulatory facility can provide, your care needs, including your Advance Directive/Living Will/Healthcare Proxy, will be honored at the receiving hospital upon your arrival.
  - C. The Surgical Care Affiliates facility requests that if you have an Advance Directive/Living Will/Healthcare Proxy, please bring a copy with you so we may place it with your medical record if needed.
  - D. If you do not have an Advance Directive/Living Will/Healthcare Proxy, you may obtain more information, including instructions on how to complete one, at your state authority of Advance Directives/Living Will/Healthcare Proxy. For your convenience, a phone number, a state website, and an Advance Directive form are provided for you in this letter.

Also, someone from the center will be contacting you prior to your arrival at the center to inform you of your financial responsibility. You are not expected to pay any co-insurance or unmet deductible, but only co-pay, on the day of service.

We hope you will find your stay and the care you receive at the Alaska Surgery Center; a Surgical Care Affiliates facility, a pleasant experience. If you have questions, please contact:

Debbie Smith

Business Office Manager

907-550-6214



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### **ADVANCED DIRECTIVE**

Our center's policy regarding Advance Directives including a description of applicable State health and safety laws:

- You have the right to make choices regarding life-sustaining treatment, including resuscitative measures.
- The Surgical Care Affiliates facility where you are scheduled to have your procedure wishes to notify you that if there is a need to transfer you to a hospital for additional care measures beyond what the ambulatory facility can provide, your care needs, including your Advance Directive/Living Will/Healthcare Proxy, will be honored at the receiving hospital upon your arrival.
- The Surgical Care Affiliates facility requests that if you have an Advance Directive/Living Will/Healthcare Proxy, please bring a copy with you so we may place it with your medical record if needed.
- If you do not have an Advance Directive/Living Will/Healthcare Proxy, you may obtain more information, including instructions on how to complete one, at your state authority of Advance Directives/Living Will/Healthcare Proxy. For your convenience, a phone number, a state website, and an Advance Directive form are provided for you in this letter.

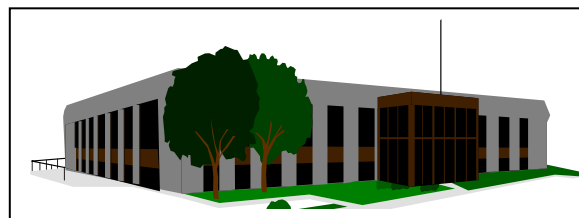
If you would like to print a copy of Alaska's Advance Directive you can do so by visiting there website: [www.caringinfo.org](http://www.caringinfo.org) or calling Caring Connections at 1-800-658-8898. You can also call us at 550-6100 and we will be happy to fax a copy to you. If it is more convenient for you they are also available for pick up at our facility.



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## **Disclosure Statement**

Dear Prospective Patient:

We are delighted that you have chosen the Alaska Surgery Center for your elective surgery.

Due to physician investment in this facility, it is required by Alaska State law that we notify you of the alternative facilities available to you.

**Providence Hospital**

3200 Providence Dr.

Anchorage, AK 99508

(907) 261-3049

**AK Regional Hospital**

2801 Debarr Rd

Anchorage, AK 99508

(907) 276-1131

Your signature below will also confirm that you have been made aware of your physician's approximate 1% ownership interest in this facility, and that you have been provided names and address of alternative facilities should you choose to use them.

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Patient Signature



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**ASC Conditions of Coverage Patient Attestation**

**Patient Name:** \_\_\_\_\_

**Date of Procedure:** \_\_\_\_\_

I certify that I have received written documentation of the following items, in advance of the date of my scheduled procedure:

1. Patient's Rights and Responsibilities
2. Advance Directives
3. Disclosure of Physician Ownership

Furthermore, I understand that this information is being provided for my benefit and that should I have any questions regarding its content, I should contact the Center for clarification.

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date